MEDICAL BOARD OF CALIFORNIA

Licensing Program

POSTGRADUATE TRAINING REGISTRATION FORM

To be completed by every medical graduate who is not licensed in California and who will commence an ACGME/RCPSC accredited postgraduate training program in California. Please complete the information below and return this form to the Licensing Program of the Medical Board of California at the above address. The filing of this form with the Board will fulfill the registration requirements specified by law.

1. NAME: Last	First		Middle
2. Date of Birth:		3. U.S. Social Security Number:	
4. Home/Mailing Address:			
5. Telephone Numbers: (include area code)	Home	Work	Cell
6. Name and Address of Medical School of Graduation:		7. Date Medical Degree Issued	
8. Is this your first postgraduate training year in the U.S.? ☐ Yes ☐ No	9. If no, list all other ACGME/RCPSC accredited postgraduate training programs in which you participated, whether or not the program was completed or credit was granted.		
10. Name and address of facility where training is to be completed:		ACGME 10 digit program number	
11. Name of the program director:		12. Program director's telephone number:	
13. List categorical specialty area of training to be completed:			
14. Beginning & Ending Dates of this program: From	To		
15. I HEREBY DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I HAVE READ THE LAWS, AND THAT THE FOREGOING INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT. Signature _____ Date _____			
COMPLETION OF THIS FORM IS REQUIRED BY SECTIONS 2065 AND 2066 OF THE CALIFORNIA BUSINESS AND PROFESSIONS CODE.			

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